



ST. CHRISTOPHER AND NEVIS SOCIAL SECURITY BOARD

CLAIM FOR MATERNITY BENEFIT (ALLOWANCE AND GRANT)

Striving for Social Justice

To be completed by insured woman

1. Social Security No.

Details of Insured Person:

Part - 1

2. FIRST NAME MIDDLE NAME(S) SURNAME

MAIDEN NAME

3. Date of Birth (dd/mm/yyyy)

4. Gender

5. Tel./Cellular No.

☐ Male ☐ Female

6. Home Address

7. P.O. Box

8. E-mail Address

9. Occupation

10. I agree for my permanent address to be updated with the address provided on this form Yes ☐ No ☐

Employer Details:

11. Name of Present/Last Employer

12. Employer's Reg. No.

13. Address of Employer

Other Employers for whom I have worked during the last three (39) weeks:

14. Name of Employer

15. I hereby claim Maternity benefit from: 16. to the date of: (dd/mm/yyyy) 17. My last day at work was (dd/mm/yyyy)

Please enter your **Bank** details for payment of your benefit:

18. Name on Account

19. Account No.

20. Name of Financial Institution

Select type of Account:- Savings ☐

Chequing ☐

21. Are you the wife of an insured man? ☐ Yes ☐ No

22. If yes, state his name

& Social Security No.

I understand that it is an offence to receive benefit in respect of any period while I am at work and therefore give the undertaking that I will be away from work for the period for which benefit is hereby claimed. Overleaf is a Medical Certificate of my expected confinement/Medical Certificate of my confinement, in support of my claim.

23. Claimant's signature

24. Date (dd/mm/yyyy)

25. Signature of Witness

26. Name of Witness

(Affix right thumb print here if unable to write)

NOTES: TIME FOR CLAIMING: Your claim for Maternity Allowance MUST NOT be made before, and for any period earlier than six (6) weeks prior to the week in which your doctor expects delivery would occur. If your claim For Maternity Allowance was not made before confinement, it must be made within three (3) weeks beginning with the date of confinement. You may be disqualified from receiving Maternity Allowance or Maternity Grant if your claim is received later than the time stipulated by the Benefit Regulations outlined above.

Warning: Any person who knowingly makes any false representation for the purpose of obtaining benefit renders herself liable for prosecution.

Form M.B.1 (Revised 2013)



Striving for Social Justice

*MEDICAL CERTIFICATE OF EXPECTED CONFINEMENT

To be completed by a Medical Practitioner in respect of the claim overleaf for Maternity Allowance BEFORE confinement. This certificate is not to be given for a period earlier than six (6) weeks before the week of expected confinement.

1.	First Name	Middle Name (s)	Surname
2.	I certify that on I examined you and you are pregnant and it is expected that you will be confined on or about		
3.	Name of Medical Practitioner		
4.	Address of Practitioner's Office		
5.	Practitioner's Signature	6. Certificate given on (dd/mm/yyyy)	Affix office stamp here

Form M.C.2 (revised 2015)

*MEDICAL CERTIFICATE OF CONFINEMENT

To be completed by a Medical Practitioner or a registered Midwife if claim for Allowance and Grant is made AFTER confinement.

1.	First Name	Middle Name (s)	Surname
2.	I Certify that I attended you at your confinement on (dd/mm/yyyy)		3. The confinement took place at (Medical facility or place)
4.	I certify that the confinement resulted in the birth of		5. Gender of child/children
6.	Name of Medical Practitioner/Midwife		
7.	Practitioner's/Midwife's Signature	8. Certificate given on (dd/mm/yyyy)	9. Midwife's Registration No.

***Form of Certificate and words not applicable should be deleted**

Form M.C.3 (revised 2015)	For Official Use	*delete words not applicable
	Date Received (dd/mm/yyyy)	
	Claim Number	
	Verification Documents Received	
	Signature of Receiving Officer	